INTRODUCTION

This preliminary report reflects my analysis of the tragic circumstances surrounding the death of Faheem Williams and the reported severe abuse of Raheem and Tyrone Williams. Specifically, I am focusing in this document on the ways the systems that serve battered and neglected children in this state may have contributed to the condition of the Williams' children.

The children served by the Division of Youth and Family Services, the state's principal child protection agency, as well as the public, deserve nothing less than an unflinchingly fair and accurate accounting of the circumstances that led to Faheem's death.

They also deserve a thoughtful and effective response to this tragedy. This response must speak not only to individual accountability but also, more broadly, to bolstering the systems that support front-line workers to ensure that they can do everything in their power to keep children safe from harm.

Described within are details of the Division of Youth and Family Service's involvement with the Williams family, a recounting and assessment of how the case was managed by front-line workers and supervisors, an evaluation of the strengths and weaknesses of the systems that support field case workers, and recommendations for improving the overall system in the short and long term.

I view this report as the jumping off point for meaningful changes in our child protection system. This will not be easy. And it will not be quick. Improving this system will require the intense and sustained attention of all of our partners in this endeavor – all branches of government, the non-profit community, the professionals who have dedicated their lives to helping children; and the public at large.

I submit this report with the full knowledge and commitment that those of us who are responsible for guiding this change have a massive job ahead of us. Today, we commit ourselves anew to the task of keeping children safe and of fulfilling our mission to provide permanency and stability to our state's most vulnerable and at-risk citizens.

BACKGROUND AND KEY STATISTICS

The Division of Youth and Family Services (DYFS) is the state's public child welfare agency serving approximately 51,000 children at any given time. They operate 24 hours a day, seven days a week. They serve almost 100,000 children and families annually. DYFS is the agency charged with the responsibility for protecting children, supporting families and conducting child abuse and neglect investigations.

Services

In CY 2000, DYFS screened and responded to 78,357 referrals. Of the total referrals, 39,176 were for abuse and neglect. There were 8,715 substantiated cases of abuse

and neglect. The current DYFS caseload is 47,336. (See Attachment A – Overview of Child Caseload).

Over 47,000 children are receiving case management services through DYFS. Approximately 36,000 receive case management in their own home and 11,000 children receive care in out of home placement. Currently, there are over 7,100 foster children in New Jersey residing in over 4,000 DYFS approved foster homes.

Each year DYFS provides services and support to over 75,000 children and families through 900 contracted community agencies. These groups provide hundreds of programs including parenting skills, respite care, counseling and homemaker services.

DYFS also operates a 24-hour hotline to receive reports of suspected child abuse and neglect during evenings, weekends and holidays. This Office of Child Abuse Control (OCAC) is linked with a statewide network of Special Response Units who respond to emergency reports.

Budget

The current Division budget is $521,619 million which does not include a $74.9 million carve out for the Children's System of Care Initiative for fiscal year 2003, which in years past was a part of the Division's budget (See Attachment B).

Employees

There are 38 DYFS field offices, including the six Adoption Resource Centers (ARCs) and an additional three residential treatment centers (RTCs). The Division currently consists of 3,643 employees, including 1,519 caseworkers/trainees, 308 front line supervisors and 71 second level supervisors.

Caseload and Length of Service

The average caseload size of a DYFS caseworker, as of December 6, 2002, is 33 children per district office worker, and 18 children per adoption worker. The average length of service for the highest level Family Service Specialist (FSS) 1 caseworker is 14.6 years; for a mid-level FSS 2 caseworker it is 4.1 years, and for an entry-level FSS Trainee it is .7 years.

The average supervisor to worker ratio is 1 to 5 for the DOs and ARCs combined. The average length of service for second supervisory level SFSS 1's in the DOs and ARCs is 23.3 years. The average length of service for frontline SFSS 2's is 16.6 years.

Child Deaths

In CY 2002, there were 17 child fatalities due to child abuse/neglect in New Jersey. Six of the children who died were involved in an open DYFS case, four were closed DYFS cases and another seven were cases unknown to the Division.

In 1997, the New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA) established in the Department of Human Services the Child Fatality and Near Fatality Review Board. The purpose of the board is to review fatalities and near fatalities of children in New Jersey in order to identify their causes, their relationship to governmental support systems, and methods of prevention.

The board is also charged with describing trends and patterns of child fatalities and near fatalities, identifying risk factors and their prevalence in these populations of children, and evaluating the responses of government systems to these populations and make recommendations for improvements of these responses.

The board reviews fatalities of children due to unusual circumstances, such as child abuse or neglect; sexual abuse; head trauma, fractures and blunt force trauma; suffocation; burns, and specifically identifies fatalities and near fatalities among children whose family, currently or within the last 12 months, was receiving services from the Division of Youth and Family Services.

The members of the board are the Commissioner of Human Services, the Commissioner of Health and Senior Services, the Director of DYFS, the Attorney General, the Superintendent of the State Police, the State Medical Examiner, the Executive Director of the New Jersey Task Force on Child Abuse and Neglect, a representative of the New Jersey Prosecutor's Association, a Law Guardian, a pediatrician, a psychologist, a social work educator, and a substance abuse expert.

CASE PRACTICE ASSESSMENT

Case Chronology and Case Handling

In an effort to understand what happened to the Williams family with regard to DYFS involvement, we investigated the case practices followed by the District Office (D.O.) in the handling of this family's case. The information provided is comprehensive yet in compliance with our obligations under confidentiality and release of information laws applicable to DYFS (N.J.S.A 9:6-8.10a, 30:4-24.3, N.J.A.C. 10:133G—1, et. seq., 42 U.S.C.A. 671(a)8, 45 C.F.R. 205.50, 1355.21, et. seq.)[1]. The analysis of the Williams family case delineates the chronology of referrals to DYFS, the findings made by the

[1] Any public release of the information provided in this section requires redaction prior thereto.

District Office and the issues discerned in the case handling in this retrospective analysis. The retrospective analysis is an effort to decipher how the Williams family's case was handled by DYFS.

The following case review is compiled by a team of staff from the Division of Youth and Family Services: Central Office Case Practice Specialists, Metropolitan Case Practice Specialists and Quality Assurance representatives. This team was gathered to review the practices and actions in the Williams family case file. We reviewed one volume of, which was presented as the entire existing file for the Williams Family. It should be noted that in addition to this case record there was a previous history on Melinda Williams as a minor parent with her daughter, K W, and son, Fuquan Williams (KC# 250978). The record was requested on January 7, 2003 from the archives and will be reviewed as well. As of this date, this review team has not received the prior closed record.

FAMILY COMPOSITION/HISTORY (SEE ATTACHMENT C):

Melinda Williams: DOB: 3/7/72; mother of Fuquan, Raheem, Faheem Williams and Tyrone Tyshone Hill, K W

MELINDA WILLIAMS' CHILDREN:

CHILD: **K W**, DOB: 1/9/89; in September of 1989, at the age of 9 months, K entered foster care for the second time. K remained in foster care until GSP was granted to the Division in January of 1995. K was subsequently adopted.

CHILD: **Fuquan Williams**, DOB: 5/5/91. Fuquan is in the legal custody of Clarence Jackson, a cousin.

CHILD: **Faheem Williams**, DOB: 6/13/95, DECEASED

CHILD: **Raheem Williams**, DOB: 6/13/95. Raheem remains hospitalized at UMDNJ. DYFS filed and obtained custody of the child and upon discharge from UMDNJ it is expected that Raheem will enter foster care placement.

CHILD: **Tyrone Hill**, DOB: 8/28/98. Tyrone remains hospitalized at UMDNJ. DYFS filed and obtained custody of the child and upon discharge from UMDNJ it is expected that Tyrone will enter foster care placement.

R S: father of Fuquan Williams;

G J C: father of Raheem and Faheem Williams;

Tyrone Hill, Sr.: father of Tyrone Tyshone Hill aka Tyrone Hill, Jr.

J H: sister of Tyrone Hill, Sr.,

H D H: paternal grandmother of Tyrone Hill, Jr./mother Tyrone Hill, Sr.,

H L H: paternal great grandmother of Tyrone Hill, Jr./grandmother of Tyrone Hill, Sr.;

S W: DECEASED; mother of Melinda Williams

P W, sister of Melinda Williams/maternal aunt of Williams' children; P W has six children: Q.M., DOB: (……); Q.W., DOB: (……..); Q.W., DOB: (…….); A.W. DOB: (…….); A.B., DOB: (…….) A.W., DOB: (…….).

J W: (…….); sister of Melinda Williams/maternal aunt of Williams' children; J W has one child, T.W. a/ka T.S., DOB: (…….).

N W: (…….); brother of Melinda Williams/maternal uncle of Williams' children

R W: DOB: (…….); brother of Melinda Williams/maternal uncle of Williams' children

R M: stepfather of P W (and presumably Melinda Williams);

S M: relative or friend of Melinda Williams (cousin or aunt?). On 10/4/96, S M's child, A., DOB: 12/31/92, was left in the care of Melinda Williams and it was substantiated that Melinda Williams beat the child with a belt and inflicted cigarette burn marks on the child, under KC……. This may have resulted in Melinda Williams' conviction for child endangerment for which she served a prison term in or about March, 2001

Sherry Murphy aka Sherry Williams: (…….); cousin of Melinda Williams; Sherry has five children: W.T. aka W.M., DOB: (……..); N.M., DOB: (……..); P. T., DOB: (……..); P.T., age ..; and O.R., DOB: (…….). The child, O.R., resides with the father and paternal grandmother. The other Murphy children reside with the father, W.T., at the home of J.G.. Mr. T. and Ms. G. are ex-spouses, having divorced some time ago.

Joseph Reese aka Joe Riece: brother of Sherry Murphy

G A: family friend of Melinda Williams; (……..) For a period of time, around August of 1999, GA had Fuquan, Raheem and Faheem Williams' residing in her home. How long these children actually resided in the home is unclear in the Division record. GA believes the time the children remained in the home was 8 or 9 months.

Y A: adult daughter of G A/family friend of Williams' family. Ms. A is interested in providing a home for Tyrone Hill and Raheem Williams.

R G aka A W aka "Aunt A G": maternal aunt of Melinda Williams/maternal great aunt of Williams' children; (…….)

C J: adult son of R G aka "Aunt A G"/cousin of Williams' children; (…….). Mr. J has legal custody of Fuquan Williams (…….)

Case Timeline:

1/21/96: Allegation: No food. Home filthy and infested with rodents and roaches.

> Finding: Unsubstantiated that there was no food. The home was adequately heated and furnished.

7/4/96: Allegation: Children are left alone. Children have been alone for several hours. No food. Children hungry and afraid. Mother goes off with her boyfriend and leaves the children alone.

> Finding: unfounded that the mother did not have food and that the children were hungry. Neglect substantiated because mother left the children 5 years and 11 months alone.
>
> Case plan is developed and mother is counseled to maintain stable housing. No services are ordered. The case remains open.

12/4/96: Allegation: Mother's boyfriend sells drugs out of the home. There is traffic in and out of the home all hours of the night. Mother leaves the children alone on numerous occasions.

> Finding: Not substantiated. People were not observed coming and going from home, mother denied drug trafficking from her apartment and children were neatly dressed.

3/4/97: Allegation: Home is deplorable with garbage, papers and clothes all over the floor. Home smells of feces and urine.
The children are left alone. Fuquan doesn't attend school and begs for food. No food in home a few days ago.

> Finding: The family was found stable. Concerns about parenting are reflected in case record because apartment was unclean and Fuquan was not attending school even though he was old enough for Kindergarten. Several relatives had been residing with mother and children.

April 7, 1997 -- Case closed. No closing summary. No collaterals. There is computer documentation that indicates it was closed. A closing summary, which is required for closing of cases, is not in the record.

10/28/97: Allegation: Mother's boyfriend burned one of the twins Faheem with hot tea a week ago. Burn is around the neck. Tea was dropped accidentally, but mother did not get medical attention.

Finding: Abuse not substantiated. Child's burn mark is very old. According to mother, burn occurred 2 years ago and doctor saw child. Case is reopened because mother did not have furniture, housing considered marginal, living situation considered transient.

Case plan is developed that involves a referral for parenting skills and a parent-aide program which assists parents in the home. Mother went to 2 or 3 parenting skills classes and did not complete course. Parenting aide only got in to see family a couple of times and contact was not sustained, primarily because of transient lifestyle. At one point, Mom lived in four different apartments in 11 months.

This caseworker continued to follow-up even though the mother had spotty compliance record. He continued to follow family around from house to house. Records indicate that he is trying to keep the aide informed on the family's location.

5/27/98: Allegation: Fuquan Williams has a laceration in the palm of this right hand.

Finding: Melinda Williams medically neglected her child, Fuquan Williams by not taking him to the doctor. Medical neglect substantiated. Caseworker sees the children. Early June caseworker can't find the family. Caseworker requests the July (…….) check be held and it was not done. Apparently the July and August checks were not held. (……..) Caseworker requests again for the September (…..) to be held. The (…….) worker tells him that Mom is working so in Oct. 1998 her (……..) are held – (……..) -- and Mom contacts the caseworker to inquire about her (…….). It is not clear if the caseworker saw the children at that time, but case notes show that the caseworker counseled the mother about keeping the children clean and on making sure they attend school regularly. Caseworker expresses concerns in the case record about possible drug use by either the mother or her paramour or both. A CADC substance abuse referral was made. The record does not indicate that any services were ordered.

It should be noted that the Essex County Prosecutor's Office was involved to some extent with the family at this time and asked the Division to request Fuquan's medical records from Newark Beth Israel. The worker faxed those records to the Prosecutor on 9/30/98. The family was also difficult to locate at this time.

Note: the children were seen in November of 1998 and February of 1999 prior to this referral.

4/27/99: Allegation: Reported Fuquan Williams has an inch cut on right thumb and mother keeps a gun under child's bed. According to Fuquan, his mother cut him with a

knife because his father approached his mother with a knife and mom keeps a gun under his bed.

Finding: Allegation that mother had a gun under child's bed unfounded. Child abuse/neglect due to child having a cut on right thumb unsubstantiated.

5/25/99: Caseworker visits and the children and mother seem in good condition.

7/28/99: Allegation: Mother left one of the children (the child was one year old Tyrone) in the care of a relative "three weeks ago" to go to Social Security Office and never returned. Mother did not leave necessary items for the child's care.

Finding: Allegations of neglect substantiated. Mother did leave the child with a relative (paternal grandmother) and did not return. DYFS allowed the child to remain there. Caseworker followed up with the relative (grandmother) to make sure the child was OK and being cared for. Caseworker does not know where Mother or other two child are at this time. It is not clear yet what, if any, actions were taken to try to find them.

August 18, 1999: DYFS gets a call (…….) who is at the hospital with Faheem (asthma attack) and needs permission to have him treated there. DYFS faxed a letter to hospital for Faheem to be treated. A review of case records indicates a new caseworker has been assigned to this family. Caseworker visits the other two children, Raheem and Fuquan, at this relative's home all on the same day. Children appear to be in good health, but still do not know where mother Melinda is.

November 10, 1999: There is another visit to the (……..) home and all three of the children (Fuquan and the twins, Raheem and Faheem) are seen. (The infant, Tyrone ,is still with the other relative --the paternal grandmother.)

June 11, 2000: Caseworker visits the (…..) and observes Fuquan who is doing well. However, (…….) indicates that she gave the other two children -- the twins -- back to Williams. She gives an address for Williams. The worker goes to that address but Williams is not there.

October 2000: (……) relinquishes custody of Fuquan and says she needs a letter to (…….) saying she no longer has the child. It is not clear where Fuquan is at this time.

Date: 1/17/01: Allegation: Apartment where Melinda Williams and the children are living has no heat and broken windows. Building is a slumlord building, according to the allegation.

Finding: Unsubstantiated. Caseworker goes to the building and finds there is heat in the apartment and no broken windows. The broken windows are in the

building but do not affect her apartment. The case continues open from the October 1997 referral.

Date: 10/3/01: Allegation: Children are being burned and beaten by mother.

Finding: The caseworker went to Murphy's home several times within a month period and Murphy confirmed that Williams lives there but Williams and the children are not there every time the caseworker calls.

November 8, 2001: Mom comes into the DYFS Newark office without the children and tells her caseworker that she is doing well and the children are doing well and indicates that (…….) is paying for her to go to school. Mother says Fuquan is doing well in New York with (…….). She indicates she will continue to live with Murphy with the three children. Williams schedules an appointment with caseworker for a home visit on Nov. 13.

November 13, 2001. Mom cancels the visit because she says she has to go to school.

November 14, 2001. Caseworker visits Murphy's home in Irvington and Williams and kids are not there. Murphy is there.

November 26, 2001: Twice on this day caseworkers go to visit and meet Murphy's brother who says that Williams is not there and the three children are in New York for the holidays.

December 10, 2001: Caseworkers go to visit at Murphy's residence and they see (…..), Sherry's brother, and they are told that they just missed Williams and the children.

December 11, 2001: DYFS workers prepare the safety assessment. Worker completes the safety assessment. The safety assessment protocol requires that the children listed be seen the day that the safety assessment is done. The caseworker indicates that the children are safe but also indicates that they cannot be found to be interviewed. A finding of safety under these circumstances is counter to DYFS policy and protocol.

Note: the case was submitted for closing to the supervisor on the same day and the record indicates it was signed off on by a supervisor two months later. This would appear to be a breach, also, of case practice protocols.

Case Practice Issues

- Issue: Upon receiving the referral of July 4, 1996, there is no indication that the District Office secured the prior case record (which detailed Melinda Williams' history with the Division). It was also indicated on this referral that the family was dually managed with the Adoption Resource Center (ARC) but there is no indication that there was communication between the ARC and the District Office staff. This

missing history detailed the mother's abuse and neglect of K, her oldest child that led to the termination of her parental rights.

Case Practice/Policy: The case history was absent and critical information was missing, which impaired the Division's ability to see a comprehensive picture. This lack of information made it impossible to see all of the mother's strengths, weaknesses, and real dangers to any children left in this mother's care. This pattern continued throughout the next nine referrals over six years.

- Issue: Several referrals were improperly coded (Family Problems vs. abuse or neglect). There were three recordings of allegations on contact sheets which were not recorded as abuse and neglect and were not investigated as such in accordance with Division policy and New Jersey State law.

  Case Examples: On March 4, 1997, a referral alleges neglect but was in fact coded family problem.

  On October 28, 1997, the referral alleges abuse but was coded family problem.

  With regard to the recording of allegations on contact sheets:

  On October 3, 2001 an allegation of abuse, which was not recorded as an abuse/neglect referral, and therefore not investigated.

  On November 8, 2001, an allegation of sexual abuse was not recorded on an incident report nor coded as such and was not investigated.

  Case Practice/Policy: State law requires that the Division investigate all allegations of abuse/neglect (IIB 210.1, IIB 303, and IIC 201).

- Issue: There were many requests throughout the history of the case for third party reports and no indication in the case record that they were received, i.e. police reports, medical and educational reports. Third party reports/ professionals were not used effectively by the Division due to the transient nature of the family. Case practice was incident driven (For example, for the referral of 5/27/98, although there was a suspicion of substance abuse and a referral was made, there is no documentation of follow-up with CADC or psychological recommendations).

  Case Practice/Policy: Failure to obtain third party reports resulted in inadequate investigations (IIA 1606, IIB 205, IIB 304). Policy requires using collaterals as a critical element of child protective services and investigations. The Division recognizes a statewide need to improve the use of collateral contacts and third party collateral recommendations. It is not enough to depend on the worker's observations alone in making a comprehensive assessment of service needs. Case

assessment protocol is that the assessment be supported by other individuals and professionals who have knowledge and information to offer about our families.

- Issue: The chronic, transient nature of the family made it difficult for various community systems (school, welfare, health care, prosecutor) to effectively coordinate and service this family.

  Case Practice/Policy: There are policy and practice issues that cross Divisional/Departmental/Community lines. Not only do the Divisions need to become more integrated in service provision, but they need to become more integrated in terms of policy development and practice. The following systems were involved in the history of this case.

  Essex County Prosecutor's Office
  Social Security Administration
  Division of Family Development
  Community school districts/New Jersey and New York
  East Orange Police Department
  Newark Police Department
  Irvington Police
  University of Medicine and Dentistry
  Pediatrician
  Family Court System (New Jersey and New York)
  Essex County Department of Citizen Services

- Issue: There was no indication of consultation with the Deputy Attorney General (DAG), during the time period when one of the children was left with a relative for three weeks with out any provisions. At different points of time throughout the case recording it was indicated that legal consultation may have been beneficial.

  Case Practice/Policy: During this time period there appears to be grounds to remove the children or at least seek court intervention for their protection and care (IIC 1302), but the Division did not follow up. The Division did not consult with the DAG (IIC 1304). The Division did not obtain authority to consent to medical care (IIK 1002.5). The children remained with caretakers the Division knew nothing about, therefore, their level of risk was unknown. In the Fall of 2001, a statewide safety assessment was implemented to ensure that every new referral includes an in-person assessment process that requires the caseworker to make direct observation of the safety of each child in the home prior to making a casework decision.

- Issue: The team noted that between the years of 1999 and 2001 there were multiple caseworkers and supervisors involved in the managing of this family which may have contributed to the fragmentation in case practice and documentation.

Case Practice/Policy: Consistency and accountability of case management planning is severely compromised (IF 206.2 and IF 208). Policy requires prompt transfer and conferencing of cases to ensure minimal breaks in case management, to enhance monitoring and to ensure continuity in case monitoring and case planning.

- Issue: Several investigations of abuse/neglect were incomplete, i.e. not all children were seen, collaterals not done. In the time frame of August 1999 until case closing, existing documentation does not reflect that a minimum visitation schedule (MVR) was followed. It appears that in 2 ½ years the children were seen once by Division staff (November 1999).

SYSTEM ASSESSMENT

Several issues regarding training have been identified, including tracking of missing families, and the management of structured decision making.

Current Training-

The DYFS Training Academy is a systematic program of studies by which the training needs of all DYFS staff are met. The Academy concept is based on the principal of regular, appropriate and incremental training for staff. The basic organizational structure of an Academy includes the following levels:

- Level 1 Entry- beginning training for all newly hired or promoted DYFS staff and appropriate community staff.

- Level II Intermediate- follow-up training to be completed within twelve months of being hired consisting of required and elective courses

- Level III- Advanced- follow-up modules and special programs offered after the first year of employment. Selection of courses at this level is based on the individual needs of the employee with a goal of career enhancement.

Staff are required to take a minimum number of training hours per year.

Additional Training Needs

Tracking Missing Families-

The ability to locate missing family members and/or alleged perpetrators is critical to providing the proper supervision of children that DYFS is charged with protecting. Caseworkers and their supervisors would benefit from structured training in conducting investigations to locate missing clients. Similar training is currently utilized by law enforcement assigned to missing persons units and fugitive apprehension units. In addition, a Missing Client Profile Checklist should be developed to ensure that caseworkers have exhausted all reasonable means to locate a missing family member

or an alleged perpetrator. The checklist should document inquiries of social services, criminal justice, law enforcement, federal, state, and local government databases. A field canvass component should also be included in the checklist. This tool, if properly utilized, should not only improve a caseworker's ability to locate a missing client but also provide assurances to the supervisor that diligent efforts were undertaken even if the client cannot be found.

Management of Structured Decision Making Training-

Our review of current administrative systems revealed an inability to effectively document and retrieve training records. Management of this training should include accurate documentation that each case manager and supervisor have received SDM training. Protocol should be established to notify the SDM coordinator of all promotions that occur for case management staff. The coordinator should ensure that all individuals who have been promoted to supervisory positions expeditiously receive additional training on the supervisory components of SDM. Additionally, an SDM database should be created to track training that case management staff have received.

Systems Assessment Attachments

The attached system assessment (Attachment D) provides a chronological history of key events that occur in the Williams case from 8/4/92 to 2/7/02. Significant events listed in the timeline have policy implications, specifically as it related to case handling and supervisory issues. These considerations include but are not limited to the following:

- Documentation standards,
- Lack of accurate contact with family members, and
- Insufficient collateral contacts

Lastly, the chronology points to management strategies for consideration when developing strategic systems reforms.

The attached Personnel Hiring and Training Information chart (Attachment E) provides a listing of the Division of Youth and Family Services (DYFS) employees who were involved in the case practice and supervision of Melinda Williams and her children from July 4, 1997 to February 7, 2002. The chart is intended to provide overall assessment criteria for each employee as a lens for viewing their respective case management in this case. The chart includes the following information:

- Name of the employee
- Date of appointment to the Department of Human Services
- Current title held by the employee
- Date on which the employee became permanent or provisional in the agency or a title
- Training attended by the employee related to their case practice and/or supervisory duties in DYFS
- Performance Assessment Review ratings and dates

SYSTEM ISSUES AND GAPS

Accountability

Caseworkers have limited assistance in identifying high priority cases. Though new cases are given specific action priority, once in a caseload, these priority cases are not readily identifiable. At a minimum, cases should have a readily visible identification that distinguishes them based on risk. A process as simple as different color file folders could be utilized.

With the exception of high risk cases, it is clear that once assigned, case closure decisions for in-home cases are all made between the worker and frontline supervisor without higher level review. Inappropriate case practice decisions can be made time and time again without anyone else's knowledge or participation. Some in–home cases are not monitored outside of the worker-supervisor relationship, thus quality can be sacrificed. If responsibility is intended, there is no mechanism for it to be exercised. It is also clear that administrators do not always successfully monitor worker caseloads.

Statewide prototypes of reporting formats must be developed to extend oversight to District Office management in an effort to improve quality assurance and accountability for case handling.

Information Technology

The Division currently relies upon a hodgepodge of computer systems. Although most of the current systems provide DYFS with useful and accurate information, these systems have been built with old technology and are not integrated. Therefore, they require repetitive data entry and manual intervention.

The fundamental flaw in the existing systems is that they were not specifically designed to comprehensively manage child welfare and child protective services cases. These systems are incapable of producing the necessary ticklers and reminders of casework activities which are now required by the evolving policy and practice in the protective services field. Just as critically, these systems do not provide unit supervisors and managers with the necessary management tools to easily identify deficiencies in case practice that place children at risk.

NJ is one of only six states that has yet to implement a Statewide Automated Child Welfare Information System (SACWIS). SACWIS systems have been federally funded to assist states with administering their child welfare/child protective services programs. These systems provide frontline staff with a comprehensive case management tool. They also permit supervisors and managers to monitor critical indicators such as caseload size and caseload activities to reduce risk. By permitting the development of online reports on these critical indicators, supervisors are afforded a greater opportunity to intervene in cases when danger signs are apparent.

Caseloads

DYFS defines a case as one child. The average caseload is 33 for caseworkers in the district offices (providing protective services, in-home services, services to children in out-of-home placement; and permanency planning). The average caseload for caseworkers in the DYFS Adoption Resource Centers is 18.

The Child Welfare League of America (CWLA) has developed Standards of Excellence for Services to Abuse or Neglected Children and their Families (Revised 1999) (See Excerpt in Attachment F). The standards suggest caseloads based on phase of the investigation (for example, initial assessments versus ongoing cases).

DYFS caseloads do not conform precisely to the categories of casework defined by the CWLA standards. DYFS does not differentiate caseload averages for initial assessment/investigation (intake units) and ongoing (generic) units. More importantly, neither the DYFS staffing policy or our use of the CWLA standards take into account the risk and intensity associated with a particular case.

Structured Decision-Making (SDM) Initiative

The Division recognized the need to improve the quality and consistency of decision-making at critical points during the Division's involvement with a family. Structured Decision-Making is a model for intervention, assessment, and service planning comprised of protocols to guide the decision-making of caseworkers and supervisory staff.

Child safety was the first key decision to be addressed, and a safety assessment tool, used to determine immediate or imminent serious harm to a child, is now operational in all DYFS field offices. The safety assessment tool is required at several intervals during

the life of a case, i.e., in response to a new referral, prior to reunification and prior to case closing. The roll out of training in the concepts of structured decision-making and the use of the safety tool began in the summer of 2001 and was fully operational for field office staff by January 31, 2002. The safety concept and tool were incorporated into DYFS new worker training and is being incorporated into the DYFS supervisory curriculum.

Screening and risk (future harm or maltreatment) assessment protocols and tools are currently in development but have not yet been implemented. Therefore, there is no tool consistently used to determine the risk to which a child is being exposed and the appropriate case practice standards to apply to mitigate such risk.

Case Practice Protocols

The Division of Youth and Family Services routinely develops and promulgates policies related to every aspect of Child Protective Services. Many of these policies derive from NJ Statutes that outline the Division's legal mandate and Federal guidelines advancing the safety, permanency and well being of children. These DYFS policies, once approved by Executive Management, are added to the DYFS on-line manual which is available to all case managers and supervisors.

For the most part these policies are there to govern, guide and standardize the screening, investigation, assessment, and conclusion of all child abuse and neglect allegations. They are developed to promote a comprehensive approach that advances safety and permanency of children.

District Office Manager's and Casework Supervisors are expected to not only know policy but to teach and to monitor its practice. While policy and other case practice tools are available for some circumstances, it is not always clear when to apply the policy, especially in the context of case monitoring.

Staff experience and turnover

Over the years there have been periods when staff recruitment and retention were significant issues. As a result, there are gaps in experience at certain levels of the organization. For example, less seasoned caseworkers were promoted to supervisory positions and, therefore, did not benefit from mentoring.

IMMEDIATE ACTION STEPS TAKEN

State of Emergency

On Wednesday, January 8, 2003 Commissioner Harris declared a state of emergency specifying:

- Local caseworkers cannot, under any circumstances, close a case if there is an open allegation of abuse or neglect and the child has not been seen.

- Caseworkers must immediately establish face-to-face contact with the 280 cases statewide where an abuse allegation has been made but the child has not been seen and must see those children by the end of the week or;

- In cases where those children cannot be found to be examined and/or interviewed, each district office is required to implement extraordinary investigative measures to locate the children.

- On those rare circumstances where closing a case without finding the child might be indicated -- for instance, with teenage runaways who are being pursued by law enforcement authorities or if a family has moved to another state -- only the DYFS director can approve the case closing.

Disciplinary Actions

Commissioner Harris has also taken swift and definitive action to demand accountability among those individuals who came in direct contact with the Williams family but did not follow procedures in their handling of the case.

- On January 8, Commissioner Harris announced the suspension of a DYFS supervisor who authorized the closing of the case last February -- despite a clear notation from the caseworker that the Williams children had not been seen for more than a year.

- The following day, the department suspended the caseworker last assigned to the Williams case because she mishandled the case and did not adequately report an allegation of abuse she received in late 2001.

Staff Reassignment

The department moved to reassign the District Office Manager for the office which had managed the Williams case.

Identifying high caseload ratios

As part of an effort to identify those workers who may be overburdened, the DYFS director is reviewing caseload ratio numbers every two weeks.

In addition, the department has ordered that an individualized corrective action plan be developed with supervisors for each worker carrying in excess of 50 cases. Workers will be offered time management training, mentoring and assistance in prioritizing tasks. Workers may also be moved off of field rotation so that they may complete the paperwork associated with cases where they have assured the children's safety and stability but have not yet completed necessary paperwork.

Establishing partnerships with union workforce

Commissioner Harris has met extensively with workers and supervisors represented by the Communications Workers of America as well as with union leadership and has reiterated her commitment to identifying the systemic issues that may have lead to or exacerbated case practice errors in the Williams case.

INITIAL RECOMMENDATIONS

1. **Station case practice specialists in every DYFS District Office in order to improve case practice and accountability. Upgrade the positions as necessary to ensure this is an attractive rung on the career ladder for talented staff.**

Case practice specialists are the people with the required focus and grasp of practice that can make the difference in improving case handling in all child protection interventions. They should be readily available in every District Office. Given the relative inexperience of many of the direct service workforce, this will help to combat any erosion in best practice by providing workers with easy access to senior, seasoned caseworkers with good practice track records.

2. **Hire and deploy additional caseworkers using a risk-based staffing system.**

A caseload is more than numbers. What is needed is the ability to establish "workloads" that make sense and take into account the complexity, intensity and expertise needed to intervene effectively with specific children and families. DYFS must incorporate such a model into the MIS system. Moreover, DYFS should hire additional caseload carrying staff and use the risk based model to determine the appropriate deployment of the staff.

3. **Implement a structured decision making system that would support consistent assessment of risk factors in every case.**

The New Jersey Risk Assessment, which will be used to determine whether a child is at low, moderate or high risk for future maltreatment, is currently in the planning stage. Development of this critical tool must be accelerated and incorporated into case practice and case closing protocols to ensure child safety statewide. This will also require comprehensive training of over 2,700 staff. Training on risk assessment concepts and protocols will be offered to 2,700 staff statewide, with an emphasis placed on supervisory accountability and the process of case conferencing. This initiative will also require implementation of the system upgrades discussed below.

4. **Accelerate the design, development and implementation of a State Automated Child Welfare Information System or SACWIS system, while immediately implementing interim IT solutions that will enable DYFS workers and supervisors to better manage, monitor and evaluate cases.**

Implementation of a state of the art SACWIS system is the ultimate solution to addressing the data management challenges faced by DYFS. While we will move aggressively to install such a system as quickly as possible, the need to develop better case tracking tools cannot wait. DYFS will immediately move to implement interim support applications.

These applications include (1) a Minimum Visitation Requirement System to record contact and visitation history; (2) a Permanency Tracking System to better monitor activities related to out of home placements; (3) Home Provider Tracking System to record all information about potential foster and adoptive homes from initial inquiry to final certification and beyond; and (4) Automatic Court Reporting system to produce the documentation required for permanency hearings, child placement reviews and periodic court reviews. The IT infrastructure must be upgraded and the interim applications phased-in by October 2003.

Given that each of these applications represents a major change for DYFS staff in the manner in which they record information and perform their day to day casework tasks, adequate training in these new systems must be provided prior to implementation to insure proper understanding and utilization of these new computer applications.

5. **Develop and implement an Integrated Quality Review. This is a system for conducting an extensive and thorough review of cases, including follow-up visits with all persons contacted as part of handling the case**.

The Quality Assessment Review is a review process in which every aspect of the service delivery system is assessed in relation to client/customer outcomes and effectiveness. One focus of the review is how well the children and family are functioning. The second focus looks at the success of the entire system in supporting best practice. The review involves interviews with parents and/or caregivers and input from stakeholders and providers. We will have outside experts, familiar with developing the process, take the lead in tailoring the review for New Jersey.